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ABSTRACT

California's K-6 Early Intervention Project was established in 1986 under the authority of California Assembly Bill 1535, Pilot Project on Hyperactivity, to provide a system of early identification and assistance to children in kindergarten through grade 6 whose behavior problems interfere with learning. This report contains evaluation findings regarding the first year of the 3-year project's implementation in San Diego City Schools. In the report, descriptive information is provided about the screening process used to identify project participants, behavioral and academic characteristics of project participants, and the types of intervention provided to students, parents, and teachers. The report contains in-depth case studies of three project participants. Recommendations to improve project effectiveness included the following: (1) develop clear guidelines to determine if children who are receiving pharmaceutical or special education interventions should be included in the project and the type of follow-up to be provided participants for the duration of the 3-year project; (2) establish a microcomputer database to maintain records of assistance given to participants; (3) study reasons why teachers referred a disproportionate number of black children to the project; and (4) evaluate the project during its final year to determine the extent to which project goals were met. Record keeping forms and related materials are appended. (Author/RH)

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San Diego City Schools
PLANNING, RESEARCH, AND EVALUATION DIVISION

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K-6 EARLY INTERVENTION PROJECT: EVALUATION OF THE FIRST YEAR OF IMPLEMENTATION

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No. 477

October 19, 1987

EVALUATION DEPARTMENT REPORT

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Abstract

K-6 Early Intervention Project: Evaluation of the First Year of Implementation
October 19, 1987

Beginning in July 1986, the K-6 Early Intervention Project has been funded in San Diego (California) City Schools for three years under California Assembly Bill 1535, Pilot Project on Hyperactivity. The purpose of the project is to establish a system of early identification and assistance to children in kindergarten through grade six whose behavior problems interfere with learning. This report contains evaluation findings regarding the first year of the project's implementation in San Diego City Schools. In the report, descriptive information is provided about the screening process used to identify project participants, behavioral and academic characteristics of project participants, and the types of intervention provided to students, parents, and teachers. The report contains indepth case studies of three project participants. Recommendations to improve project effectiveness included the following: 1) clear guidelines be developed to determine if children who are receiving pharmaceutical or special education interventions should be included in the project and the type of follow-up to be provided participants for the duration of the three-year project; 2) establish a database on microcomputers to maintain records of assistance given to participants; 3) study reasons why teachers referred a disproportionate number of Black children to the project; and, 4) evaluate the project during its final year to determine the extent to which project goals were met.

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K-6 EARLY INTERVENTION PROJECT:
EVALUATION OF THE FIRST YEAR OF IMPLEMENTATION

Prepared by

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October 19, 1987

San Diego City Schools
Planning, Research, and Evaluation Division
Evaluation Department
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Table of Contents

	Page
List of Tables	iv
List of Appendices	iv
Executive Summary	v
I. ISSUE/CONCERN	1
II. BACKGROUND	1
III. EVALUATION DESIGN	3
IV. FINDINGS	5
V. SUMMARY AND CONCLUSIONS	18
VI. RECOMMENDATIONS	21
VII. REFERENCES	22

List of Tables

Table		Page
1	Distribution of Project Participants Among Grade Levels	8
2	Percentile Ranks by Quartiles in Reading, Language, and Mathematics for Project Participants	9
3	Health/Physical, Speech/Language, Education, and Personal/Social Problems Indicated for Project Participants in Descending Order of Frequency.	10
4	Mean Ratings and Standard Deviations of Ratings Assigned to Project Participants by Teachers and Parents.	11
5	Types of Assistance Requested from the Counseling Center for Project Participants.	13

List of Appendices

Appendix		Page
A	Consultation Team Process: Teacher Rating Scale.	23
B	Consultation Team - Request for Support Services	27
C	K-6 Early Intervention Project Parental Permission Form	31
D	Health Services Developmental History.	35
E	IOWA Conners Parent-Teacher Questionnaire.	45
F	Student Assistance Referral Pass	49
G	K-6 Early Identification-Intervention Project Interview Form	53

SAN DIEGO CITY SCHOOLS
Planning, Research, and Evaluation Division
Evaluation Department

K-6 EARLY INTERVENTION PROJECT: EVALUATION OF THE FIRST YEAR OF IMPLEMENTATION

Summary

October 19, 1987

I. ISSUE/CONCERN

Beginning in July 1986, the K-6 Early Intervention Project has been funded in San Diego Unified School District for three years under Assembly Bill 1535, Pilot Project on Hyperactivity. The purpose of the project is to establish a system of early identification and assistance for children in kindergarten through grade six whose behavior problems interfer with learning. This report contains findings regarding the first years of the project's implementation in San Diego Unified School District. It describes the screening process, the children identified for intervention services and recommendations for staff action are offered.

II. EVALUATION FINDINGS

Key findings of the evaluation study are presented below in summary form.

1. A five-step screening procedure consisting of parent and teacher referrals, health and developmental history, questionnaires, and assistance through the consultation team process and the counseling center program was developed and implemented by the Guidance Services Department to identify children in four elementary schools who might benefit by inclusion in the K-6 Early Intervention Project.

2. One hundred and fifty-two children, or 5.8 percent of the combined student enrollment of the four project schools were included as project participants. Follow-up interviews with the consultation teams at the four schools were conducted during spring 1987. Twenty more children who were not currently included in the project but might benefit from the early intervention were identified. Many of these children had not been originally referred because the parents or teachers did not perceive the children to be in need of the intervention services, or the children were receiving other interventions.

3. All or nearly all of the teachers had referred students to the K-6 Early Intervention Project at two of the project schools (Alcott and McKinley). At two of the schools (Hickman and Logan), slightly over half of the teachers referred students for intervention services.

4. Eighty percent of the project participants were boys, and 20 percent were girls. Fifty project participants (32.9 percent) were identified as Hispanic; 66 participants (43.4 percent) as White; 31 participants (20.8 percent) as Black; three participants (2.0 percent) as Filipino; and two participants (1.3 percent combined) as American Indian and Pacific Islander. Black students were overrepresented more than ten percent among project participants at two of the project schools. They were underrepresented at the other two project schools

5. The performance of the project participants on the Comprehensive Tests of Basic Skills indicated a wide variability in their levels of academic achievement which ranged from zero to the 99th percentile. Many project participants earned percentile ranks at or above the publishers' test norm of the 50th percentile for grade-level performance (40.5 percent of the participants in reading; 27.4 percent in language; and 37.6 percent in mathematics). However, the percentile ranks for the total group were skewed toward the lower end of the distribution.

6. Ninety percent of the project participants displayed extremely active or restless behavior. Seventy percent had trouble staying on task, and approximately 50 percent had poor peer relations or difficulties with self-control. These characteristics correspond to the symptoms of the children to be targeted as recipients of the early intervention by A.B. 1535.

7. As indicated by their IOWA Conners pretest and posttest rankings of project participants, the teachers perceived their students' behavioral problems to be more severe in February (pretest) then they did in June. The teachers ranked their students as displaying more serious problems than the parents' ratings. However, the teachers' posttest rankings more closely corresponded to the parents rankings than did their pretests rankings.

8. Item-by-item analysis of the teachers' rankings and the parents' rankings on the IOWA Conners indicated that the teachers tended to view inattention and over-active behaviors as more of a problem, and the parents viewed aggressive behaviors as greater problems for the same children. This finding suggests that the intervention services to teachers need a different focus from those made available to parents.

9. Twenty-eight percent of the referrals made to the counseling centers at the four project schools were for individual counseling interventions; 22 percent were for time-out; and, eight percent were for problem-solving. Other types of counseling interventions were for reward and recognition and group counseling. The referrals came about primarily for specific behavioral incidents that caused disruptions in the classroom and counseling assistance was provided on an individual basis with the student.

10. In-depth case study profiles of three project participants showed that each of the students had difficulty staying on task, made disruptive noises, and had poor peer relations. Academically, two of the three students were achieving close to the publisher's norms for grade-level performance on the CTBS, and all three were considered by school staff to have at least average abilities. Two of the three students were likely to attend another school in the fall. The ways in which follow-up will be provided to these students were not clearly specified at the end of the school year.

III. RECOMMENDATIONS FOR STAFF ACTION

The following recommendations are drawn from the evaluation findings.

1. It is recommended that guidelines be developed to determine whether children who are receiving pharmaceutical or special educational interventions should be included as participants in the K-6 Early Intervention Project. Clear guidelines also should be developed to establish the type of follow-up which will be provided for project participants for the duration of the three-year project.

2. It is recommended that the Guidance Services Department establish a database on microcomputers to maintain records of the assistance provided to the project participants, nature of any serious disciplinary offenses, and the success or failure of the child in completing the school program to conform with A.B. 1535 guidelines.

3. It is recommended that the Guidance Services Department study reasons why teachers referred a disproportionate number of Black students to the project, collect comprehensive information on the interventions attempted, and evaluate the efficacy of the interventions over the three-year duration of the project.

4. It is recommended that the K-6 Early Intervention Program be evaluated during the final year of implementation to determine the extent to which the project goals on staff participation, parent participation, and community involvement are met through activities such as inservice to teachers and parents, coordination of community resources, and counseling interventions for parents and students.

IV. RATIONALE

The recommendations are based on evaluation findings that resulted from careful study of student records, counseling center records, and information maintained by the Guidance Services Department for the K-6 Early Intervention Project. Analyses of these data generated the evaluation findings, conclusions, and recommendations. Each recommendation addresses an identified program need.

V. BUDGET IMPLICATIONS

No immediate budgetary implications above the state funding for the pilot project for the 1987-88 and 1988-89 fiscal years are foreseen.

K-6 EARLY INTERVENTION PROJECT:
EVALUATION OF THE FIRST YEAR OF IMPLEMENTATION

I
ISSUE/CONCERN

Beginning in July 1986, the K-6 Early Intervention Project has been funded in San Diego Unified School District for three years under Assembly Bill 1535, Pilot Project on Hyperactivity. The purpose of the project is to establish a system of early identification and assistance for children in kindergarten through grade six whose behavior problems interfer with learning. This report contains findings regarding the first years of the project's implementation in San Diego Unified School District. It describes the screening process, the children identified for intervention services and recommendations for staff action are offered.

II
BACKGROUND

The San Diego Unified School District has been funded under A.B. 1535, Pilot Project on Hyperactivity to establish a primary prevention program that would provide early interventions for those children in kindergarten and grades one through six not currently served by an existing program. The project was also established with the Lincoln School District within San Joaquin County and the Long Beach Unified School District within Los Angeles County. A Joint Task Force of the California State Department of Justice and the Department of Education was established to oversee the implementation of the pilot project. The legislation provides a total of $210,000 to fund the pilot project for three years beginning July 1, 1986. Each school district was allocated $70,000 for the 1986-87 school year.

As described in Chapter 12 of A.B. 1535, Pilot Project on Hyperactivity, Section 1100, the legislature finds that there is a high correlation between hyperactivity in children and juvenile delinquency (Satterfield, 1983). Studies have indicated that between five and fifteen percent of school-age children may be identified as hyperactive. For the purposes of this project, hyperactivity is defined as "attention deficit disorder with hyperactivity" as listed in the Diagnostic and Statistical Manual, Third Edition (DSM-III) of the American Psychiatric Association. The peak age of referral for attention deficit disorder with hyperactivity is between eight and ten years, and the following symptoms are specified: <u>inattention</u> (often fails to finish things he or she starts, often doesn't seem to listen; easily distracted; has difficulty concentrating on school tasks or other tasks requiring sustained attention, has difficulty sticking to a play activity); <u>impulsivity</u> (often acts before thinking, shifts excessively from one activity to another; has difficulty organizing work; needs a lot of supervision; frequently calls out in class; has difficulty awaiting turns in games or group situation); and, <u>hyperactivity</u> (runs about or climbs on things excessively; has difficulty sitting still or fidgets excessively; has difficulty staying seated; is always "on the go"). The onset usually occurs before the age of seven and the duration is of at least six months.

In San Diego Unified School District, A.B. 1535 was implemented as the K-6 Early Intervention Project beginning September 1986. The project was implemented in four elementary schools that had established a consultation team process and a counseling center program which focused on early identification and prevention activities. The four project schools were Alcott, Hickman, Logan, and McKinley. They were selected by Guidance Services administrative staff based on the following criteria: 1) representative of different geographic areas of the district; 2) an established counseling center at each school; and, 3) existence of a consultation team process. The combined enrollment of the four project schools was 2,621 students, and it was anticipated that five to ten percent of the students would be identified as project participants.

The goals of the district's K-6 Early Intervention Project, as stated in the Guidance Services' Narrative Report, are given below.

1. To develop a school-based program of identification and intervention for children designated as in need of assistance.

2. To establish a training and resource support program for teachers and parents of the identified project participants.

The project's objectives, as stated in the Narrative Report, are given below.

a. Student Identification

   Project staff will participate in systematic screening and team conferences to identify participants, as measured by project-developed and established checklists, records, and surveys.

b. Early Intervention

   Students identified as project participants will demonstrate significant improvement in behavior, attendance, and/or achievement following participation in intervention measures established by the program.

c. Staff Participation

   Administrators, counselors, teachers, and paraprofessionals will reinforce and support the project activities as measured by surveys, records, and interviews.

d. Parent Participation

   Parents will learn effective methods to support their children's personal/social, educational, and health needs and development as measured by parent participation records, surveys, and interviews.

e. Community Involvement

   All appropriate community resources will be utilized to support the project's activities as measured by project communications, surveys, and records.

The 1986-87 evaluation of the K-6 Early Intervention Project was designed to provide documentation of the process followed to identify students as project participants and provide descriptive information about the participants. The evaluation questions that were studied are presented below.

1. What was the screening process by which students were identified as participants in the K-6 Early Intervention Project?

2. Were all of the students in need of early intervention identified by the screening process?

3. What were the characteristics of identified project participants in terms of grade level, gender, racial/ethnic groups, and primary language?

4. What was the academic achievement of the project participants as measured by the Comprehensive Tests of Basic Skills (CTBS)?

5. What were the characteristics of the project participants in terms of speech/language factors, education factors, personal/social factors, and health/physical factors (as indicated on the Consultation Team Request for Support Services form)?

6. How reliable was the IOWA Conners Teacher-Parent Questionnaire on project participants who rated by teachers at two different time intervals during the school year? How did teachers' ratings compare to parents' ratings of the same project participants?

7. What were the reasons stated by school-site staff for referring the project participants to counseling center programs at the four project schools?

8. What were the in-depth case study profiles of selected students identified as project participants?

III
EVALUATION DESIGN

The chief goal of the evaluation was to provide information about the efforts made by the district to identify and assist students who participated in the K-6 Early Intervention Project in Alcott, Hickman, Logan, and McKinley. Interviews with Guidance Services' administrative staff and district counselors at the four project schools were conducted to determine the process by which students were identified as project participants. The resource district counselor conducted follow-up interviews with the consultation team members during spring 1987 to determine if all students in need of intervention were identified.

The second goal was to provide descriptive statistics on the project participants in terms of grade level, gender, racial/ethnic groups, and language codes. Information about selected characteristics of the participants such as speech/language factors, education factors, personal/social factors, and health/physical factors were obtained from the Consultation Team - Request for Support Services form completed on all project participants. Information on the children's academic achievement was obtained from the Comprehensive Tests of Basic Skills (CTBS) administered in all schools in April 1987 as part of the district's testing program.

The reliability of the IOWA Conners' Teacher-Parent Questionnaire scores was examined. The IOWA Conners' Teacher-Parent Questionnaire (Conners, 1969) consists of ten overlapping teacher and parent items designed to identify children with attention deficit disorder with hyperactivity, differentiate between the inattention/overactivity and aggression dimensions of hyperactivity, and to evaluate treatment effectiveness. The child is rated on a four-point scale on ten items identified as symptoms of attention deficit disorder with hyperactivity. The predictive validity and differential validity of the inattention/overactivity and aggression items have been widely studied (see Conners, 1969; Goyette, Conners, and Ulrich, 1978; Johnston & Pelham, 1986; Pelham, Milrich & Murphy, unpublished manuscript). Teachers completed the IOWA Conners for all project participants in February 1987 and again in June 1987; parents during spring 1987.

The final goal was to examine in greater depth through existing information contained in school records, the children referred to the project. The reasons for referring project participants to the counseling center programs at the four project schools as stated on the Student Assistance Referral Pass forms were studied and the referring teacher's comments were categorized in terms of recurrent content. Three children identified by the district counselors were selected as typical project participants. Case studies were prepared for each child using records maintained in the counseling center to describe the child's academic and behavioral characteristics, describe the interventions, and outcomes that occurred by the completion of the K-6 Early Intervention Project's first year. The three children were enrolled at the same elementary school.

Project schools. A school program summary (Consolidated Application School Site Plans, 1986-87) for the four project elementary schools is presented below. The A.B. 1535 monies funded three guidance aide positions and a resource district counselor position one day a week to coordinate the project. District funds are used for one guidance aide position.

Alcott School is located in the Clairemont section of San Diego and houses a kindergarten program and grades one through five. The majority population is reported as 62 percent and the minority population, 38 percent. Alcott has a Voluntary Ethnic Enrollment Program (VEEP) with approximately 55 children bused there from Balboa and Emerson schools. Seventy-five percent of the VEEP students are of Hispanic ethnicity, and second language instruction is needed for approximately three-quarters of the VEEP student population. Other supplemental programs at Alcott include the School Improvement Program, Basic Skills Assistance Program, and Special Education Infant Program. The school enrollment in May 1987 was given as 527 students including 196 children (birth to age three) enrolled in the Infant Program. A district counselor is available on the site two full days a week, and a guidance aide is available for five hours daily in the counseling center program.

Hickman School is at the far western end of Mira Mesa and serves children in kindergarten and grades one through six. The school enrollment in May 1987 was 660 students. Supplemental programs include the School Improvement Program, Basic Skills Assistance Program, and approximately 26 third and fourth graders are identified as gifted and served in the gifted and talented program. Approximately 19 children have been identified as Limited English Proficient (LEP) and receive small group instruction in the district-developed English for Limited English Proficient Students (ELEPS) program. The district counselor is available on site two days a week, and a guidance aide for five hours daily.

Logan School is located on Ocean View Boulevard and serves 842 children in a kindergarten through grade six program. The school is on a single track year-round schedule. The ethnic/racial composition of Logan was reported to be the following: Hispanic students, 79 percent; White students, two percent; Black students, 17 percent; and, Indochinese students, one percent. A total of 348 students, identified as LEP receive second language instruction from their classroom teachers. There are three special education classrooms at Logan. Supplemental programs include the School Improvement Program, the Chapter 1 Compensatory Education Program, and the Basic Skills Assistance Program. The district counselor is available at Logan two days weekly, and a guidance aide for five hours daily.

McKinley School is a kindergarten through grade six school with an enrollment of 592 students. McKinley is centrally located in an older, residential section of San Diego. The student population is primarily composed of White students, and approximately 67 minority students are bused into McKinley as part of the VEEP. Second language is available for LEP students. There are three special education classrooms at McKinley. Beginning with the 1987-88 school year, McKinley will participate in the School Improvement Program. The Basic Skills Supplementary Assistance Program is available at the site. The district counselor is available on site two days a week, and the guidance aide is available five hours each day in the counseling center.

IV
FINDINGS

The evaluation findings are presented in the following order in this section of the report:

1. Screening process used at the four elementary schools to identify children as project participants;

2. Descriptive characteristics of the project participants as a group in terms of grade level, gender, academic achievement, problems identified by the classroom teachers in the health/physical, speech/language, education, and personal/social areas;

3. Reliability of the IOWA Conners Teacher-Parent Questionnaire ratings of project participants; and,

4. Analysis of the reasons that the project participants were referred to the counseling center program, and in-depth case study profiles of three project participants.

Screening process. The steps followed to identify project participants at the four schools are summarized as follows:

Step One: Teachers at each project school, following the guidelines specified on the Teacher Rating Scale (contained in Appendix A), assigned a priority rating of "1," "2," or "3" to all students in their classrooms. Students who were assigned a priority rating of "3," that is, when the teacher believed that the student had severe problems in academic, personal/social, health, and/or speech/language areas, were referred to the consultation team process at the school.

Step Two: Classroom teachers completed a Consultation Team Request for Support Services form (contained in Appendix B) on all students with a "3" priority rating. These students were processed through the school site's consultation team. A staff action plan which could include site changes, support services needed, or referral to special education was developed. Students who were "extremely active, restless, and/or fidgety" (item #4 under Health/Physical Factors) were referred to the K-6 Early Intervention Project.

Step Three: The Parental Permission Form (contained in Appendix C) was signed by parents, and a Health Services Developmental History (contained in Appendix D) was obtained from the parents of all project participants.

Step Four: The IOWA Conners Parent-Teacher Questionnaire was completed by the classroom teachers (pretest) and also by each parent. The teachers completed the Conners a second time later in the school year (posttest). A copy of the IOWA Conners is contained in Appendix E.

Step Five: Student Assistance Referral Passes to the counseling center were maintained on all project participants at the school site. The Student Assistance Pass is contained in Appendix F. Information from the passes was used to study the reasons that project participants were referred to the counseling center, and the interventions given.

Informal interviews conducted with school-site staffs by the Evaluation Department staff indicate that the students in need of early intervention were primarily referred by the classroom teacher following the five-step referral process. The majority of students for whom the teachers had indicated "extremely active, restless, and/or fidgets" on the Consultation Team referral form (90.8 percent) were included in the project. Other project participants were referred by the district counselor, school nurse, or consultation team.

A combined total of 152 students (5.8 percent) were identified as project participants at the four schools. The percent of the student enrollment identified as project participants at each of the four schools were as follows: Alcott, 6.3 percent; Hickman, 4.7 percent; Logan, 6.4 percent; and, McKinley, 7.8 percent. The percent of teachers at each of the four schools who had referred students to the project are given below:

Alcott - 11 teachers (91.7 percent of teaching staff)
Hickman - 15 teachers (60.0 percent of teaching staff)
Logan - 19 teachers (67.9 percent of teaching staff)
McKinley - 17 teachers (100.0 percent of teaching staff)

Alcott and McKinley had full or nearly full participation of the teachers in referring students to the Early Intervention Project. Hickman and Logan had slightly over half of the teachers referring students to the project. All four schools had a consultation team and resources for the counseling center. The reasons why fewer teachers were making use of the K-6 Early Intervention Project as a resource at Hickman and Logan are not obvious, but should be closely examined by Guidance Services.

During April 1987, a follow-up interview was conducted by the resource district counselor to identify other students who were not identified as project participants in the initial screening. The interview was conducted with the consultation teams at each project school and is contained in Appendix G. Twenty students in the four project schools combined were identified as in need of early intervention. The reasons given as to why these students were not originally identified included parents who refused to have their child participate, student who was new to the school, inconsistent reports from teachers, a very structured teacher who was able to handle the student, and several students who were already on medication for hyperactivity. Three students who were considered "hyperactive" had not been referred because they were currently enrolled in special education. The guidelines for including students or excluding students from the project are unclear, particularly for those students who were receiving pharmaceutical or special educational interventions. The legislation (A.B. 1535) states that the project should provide assistance to children not currently being served by other programs.

Project participants. Eighty percent of the project participants were boys, and 20 percent were girls. Table 1 shows the distribution of project participants among the different grade levels and the findings are summarized below. Alcott does not have a sixth grade which means fewer sixth graders are included in the total project overall.

- The highest percent of project participants were first graders (24.3 percent or 37 children); followed by third graders (16.5 percent or 25 children); fourth graders (13.8 percent or 21 children); fifth graders (13.2 percent or 20 children); kindergarteners (12.5 percent or 19 children); and, second graders (11.8 percent or 18 children). Sixth graders were at three of the project schools (Hickman, Logan, and McKinley) and composed 7.9 percent (12 children) of the population of project participants.

- The high percent of young children in the project lends support, along with other recent evaluation reports of children in need of special interventions (Special Education Annual Program Evaluation, Evaluation Report No. 473, October 6, 1987; Promotion and Retention Policy Implementation Study, Evaluation Department Report No. 463, June 30, 1987; Annual Evaluation of Basic Skills Supplementary Assistance Program, Evaluation Department Report No. 449, November 4, 1986), indicate that the very young children are the most frequent recipients of interventions provided by the district.

TABLE 1
DISTRIBUTION OF PROJECT PARTICIPANTS
AMONG GRADE LEVELS

	Project Participants	
Grade	Number	Percent
K	19	12.5
1	37	24.5
2	18	11.8
3	25	16.5
4	21	13.8
5	20	13.2
6*	12	7.9
Total	152	100.0

*Only includes Hickman, Logan and McKinley participants.

Information on representation of the project participants among different racial/ethnic groups was available for all 152 participants. The distribution among the racial/ethnic groups was as follows:

- Fifty Hispanic students (32.9 percent); 66 White students (43.4 percent); 31 Black students (20.4 percent); 3 Filipino students (2.0 percent); and one each American Indian and Pacific Islander (1.3 percent combined).

- The combined enrollment on the students from the racial/ethnic groups at the four project schools indicates that Hispanic students are underrepresented in the project by 4.5 percent; White students overrepresented by 3.7 percent; Black students overrepresented by 9.6 percent; and Filipino students underrepresented by 4.1 percent.*

- Compared to their representative numbers at the individual project schools, Black students were substantially overrepresented (10.4 percent and 11.9 percent) among the project participants at two of the project schools, and somewhat underrepresented at the other two schools.* The reasons why teachers at these two schools rated Black students as having severe problems needs more examination.

As part of the district's testing program, students at all grades in the four project schools were administered the CTBS during April 1987. Table 2 shows the numbers and percents of project participants who scored in the first, second, third, and fourth quartile in their total reading, total language, and total mathematics subtests of the CTBS. The project participants earned percentile ranks ranging between zero and the 99th percentile in total reading, fourth and the 96th percentile in total language, and first and 98th percentile in total

*Based on Pupil Ethnic Census, November 17, 1986.

mathematics. For reading and mathematics, most of the project participants earned percentile ranks below the first quartile (0-24th percentiles). For language, most earned percentile ranks below the second quartile (25-49th percentiles). Interestingly, a fair percent of the project participants earned percentile ranks at or above the CTBS publishers' norms of at or above the 50th percentile for grade level performance (quartile 3 and 4): 40.5 percent in reading; 27.4 percent in language; and, 37.6 percent in mathematics. However, the percentile ranks for the total group were concentrated at the lower end of the distribution. Test scores were not obtained for all project participants; many were identified as LEP students, were absent during the testing, or had moved from the project school.

TABLE 2
PERCENTILE RANKS BY QUARTILES IN READING,
LANGUAGE, AND MATHEMATICS FOR PROJECT PARTICIPANTS*

	Reading		Language		Mathematics	
Quartile	Number	Percent	Number	Percent	Number	Percent
Below Q1	32	34.0	22	35.5	32	40.0
Below Q2	24	25.5	23	37.1	18	22.4
Below Q3	23	24.5	10	16.1	19	23.8
Above Q3	15	16.0	7	11.3	11	13.8
Total	94	100.0	62	100.0	80	100.0

*From Comprehensive Tests of Basic Skills (CTBS) administered April 1987.

On the first page of the Consultation Team - Request for Support Services form (Appendix B), classroom teachers checked specific problems that project participants had in the following areas: health/physical; speech/language; education; and personal/social. Table 3 shows the numbers and percents of the project participants who had problems indicated in each area in descending order of the frequency of the problems. Under Health/Physical factors "extremely active or restless" was indicated as a problem for 90.8 percent of the participants. It might be noted that this item was used to identify children who might benefit from the K-6 Early Intervention Project. Other problems indicated for 50 percent or more of the participants were as follows:

- "Difficulty staying on task," 71.1 percent;
- "Poor peer relations," 54.6 percent; and,
- "Poor self-control; temper tantrums," 50.0 percent.

At least one-third of all project participants had problems indicated in each of the education areas such as having academic difficulties, difficulty changing activities, being easily discouraged or frustrated, poor handwriting or reversals, poor retention of subject matter, and difficulty comprehending directions. Many project participants had problems in the personal/social area such as challenging authority; defiant or having feelings of inadequacy.

TABLE 3
HEALTH/PHYSICAL, SPEECH/LANGUAGE, EDUCATION, AND PERSONAL/SOCIAL PROBLEMS INDICATED FOR PROJECT PARTICIPANTS* IN DESCENDING ORDER OF FREQUENCY

I. Health/Physical Factors	Number	Percent
a. Extremely active or restless	138	90.8
b. Poor motor coordination	37	24.3
c. Pale, listless, or apathetic	22	14.5
d. Health problems	17	11.2
e. Frequent absences/truancies	16	10.5
f. Possible deficit: vision/hearing	15	9.9
g. Frequent somatic complaints	8	5.3
h. Growth/development lag	8	5.3
II. Speech/Language Factors	**Number**	**Percent**
a. Needs directions repeated	57	37.5
b. Difficulty relating ideas	30	19.7
c. Articulation problems	27	17.8
d. Responds inappropriately	27	17.8
e. Incomplete sentences	26	17.1
f. Unusual rhythmn/fluency	22	14.5
g. Poor voice quality	12	7.9
h. Difficult to understand	10	6.6
III. Education Factors	**Number**	**Percent**
a. Difficulty staying on task	108	71.1
b. Academic difficulties	70	46.1
c. Difficulty changing activities	70	46.1
d. Problems completing work	64	42.1
e. Easily discouraged or frustrated	61	40.1
f. Poor handwriting or reversals	60	39.5
g. Poor retention of subject matter	54	35.5
h. Difficulty comprehending directions	51	33.6
IV. Personal/Social Factors	**Number**	**Percent**
a. Poor peer relations	83	54.6
b. Poor self-control; temper tantrums	76	50.0
c. Challenges authority; defiant	60	39.5
d. Feelings of inadequacy	56	36.8
e. Shows little empathy	49	32.2
f. Seems unhappy; moody	45	29.6
g. Exaggerates; lies	35	23.0
h. Generally withdrawn; timid	12	7.9

*152 project participants.

IOWA Conners. The teachers rated project participants twice during the year (pretest in February and posttest in June) on the IOWA Conners Parent-Teacher Questionnaire (Appendix E), and parents rated their children once. The IOWA Conners contains ten items. Children are assigned one of four possible ranks ranging from a score of zero to three, e.g., "not at all" to "very much" for each of the ten symptoms such as disturbs other children, is excitable, and has temper outbursts. The highest possible score on the IOWA Conners is thirty points. Table 4 contains the mean scores on the IOWA Conners for the teachers' first ratings in February 1987 (pretest); teachers' second ratings in June 1987 (posttest), and the parents' ratings during spring 1987. The teachers assigned their students the higher rankings on the pretest than on the posttest. This suggests that the teachers were perceiving their students to have more severe behavioral problems in February (pretest) than in June (posttest). The correlation coefficient between the teachers' pretest and posttest ratings was a .66 which indicates a moderate relationship between the teacher's two rankings of the project participants. The parents' average rankings were lower than the teachers rankings on both the pretest and posttest with a statistically significant difference noted between the teachers' pretest rankings and the parents' rankings. Although the teachers' rankings on the posttest were higher than the parents' rankings, they did not differ significantly.

TABLE 4
MEAN RATINGS AND STANDARD DEVIATIONS OF RATINGS
ASSIGNED TO PROJECT PARTICIPANTS BY TEACHERS AND PARENTS

	Mean	Standard Deviation
Teachers' Pretest Ratings	18.9	5.8
Teachers' Posttest Ratings	17.1	6.5
Parents' Ratings*	16.4	8.0

*Parents' ratings differed significantly from teachers' pretest ratings (t-test=2.31; degrees of freedom=60; probability <.01).

Item-by-item analysis of the teachers' and parents' ratings of the project participants on the IOWA Conners indicated that the teachers ranked students lower on most items measuring aggressive behaviors (quarrelsome, acts "smart," temper outbursts, defiant) than did the parents. One exception was that parents ranked their children lower on displaying "uncooperative" behavior than did the teachers. The teachers ranked items measuring inattention and overactivity (fidgeting, hums and makes other noises, excitable and impulsive, inattentive, and short attention span) as more troublesome than did parents. This finding suggests that the teachers and the parents were each viewing different sets of behaviors (aggressive behaviors versus inattentive/overactive behaviors) as problematic. Interventions conducted with parents as part of the K-6 Early Intervention Project may need to focus on management of aggressive behaviors while interventions for the classroom need to focus on management of the inattentiveness and overactiveness. Correlations between the teachers' rankings

on IOWA Conners items on the pretest and posttest were examined. Items measuring temper outbursts and fidgeting behavior were ranked most reliably by the teachers among the ten items, but it needs to be noted that the correlational coefficients (.70 and .63, for items #8, temper tantrums, and #1, fidgeting behavior, respectively), are considered only moderate.

In general, the teachers ranked project participants as having more serious behavioral problems than did the parents. Although, the teachers ranked the behavioral problems to be less serious in June (posttest) than in February (pretest). It is interesting to note that the teachers and parents found different dimensions of attention deficit disorder (as measured by the IOWA Conners) to be more severe problems for the project participants, that is, the teachers assigned high rankings to inattentive and overly active behaviors and the parents to aggressive behaviors. Given the short time interval (4 months) between the pretest and posttest, one suspects the difference in the teachers' rankings was due to a change in their perception about the seriousness of the behavioral problems than "true" intervention effects. Possibly, as the teachers interacted with counseling and resource staff and parents through the consultation team process and used the school-site counseling center, they became better able to handle students and perceived the behavioral problems as less severe.

Student assistance passes. Records were maintained in the counseling center at each project school on the reasons why project participants were referred to the counseling centers for assistance during the year, and the types of assistance provided. The Student Assistance Passes, as completed by the classroom teacher and district counselor or guidance aide, served as the data source. The teacher completing the pass checked the purpose for the referral (individual counseling, problem solving, time-out, reward and recognition, group counseling, or guidance groups) along with comments to indicate the reason for the referral in more detail. A copy of the Student Assistance Referral Pass is contained in Appendix F. Seven hundred and ninety-two passes were examined to determine the reasons why project participants from the four schools were referred by their teachers for assistance, and identify the types of intervention provided by the counseling center staff. It needs to be noted that the participation of project participants in the "growth groups" conducted by the counseling centers was not recorded on the student assistance passes. Table 5 presents the types of counseling assistance requested on the passes in terms of numbers and percents. Unfortunately, the reason for referral was not indicated on one-third of the student passes (266 passes). Most of the incompleted student passes were from one of the project schools. It is important to maintain accurate and comprehensive records for the project.

TABLE 5
TYPES OF ASSISTANCE REQUESTED FROM THE
COUNSELING CENTER FOR PROJECT PARTICIPANTS

Assistance Types	Number	Percent
Problem-solving	61	7.7
Individual counseling	224	28.3
Time-out	174	22.0
Reward and Recognition	14	1.8
Group counseling	5	0.5
Other†	48	6.1
Not indicated	266	33.6

†Includes requests for parent contact, dealing with defiant behavior from student, or as an intermediate step before referral to the principal.

Twenty-eight percent of the referrals to the counseling center (224 students) were for individual counseling sessions. Some examples of teachers' comments that accompanied the requests for individual counseling and the counselor's comments on the return pass are presented below. The word "student" has been substituted in place of the students' actual names to maintain confidentiality.

> Being loud in the room and refuses to be quiet; making car noises, throwing crayons. (Counselor's comments: Student and I talked about the class rules - he says he can follow the rules and is ready to return to class. Send back, if necessary.)
>
> Constantly out of seat and talking all day. Not following directions, being disruptive. (Counselor's comments: Student is going to be on a behavioral contract. Would you please fill it out for him. His reward is computer time. Student is ready to return to class.)
>
> Student has been going down hill this week. He is disrupting the class. He is telling others that he hates them. (Counselor's comments: Student has thought of some other ways that he can deal with other people. He is going to make a renewed effort.)
>
> Could the student bring her work folder to the CC tomorrow? I will help her get started on her work. She says she has a hard time blocking out noises in and out of the room and can't concentrate. (Counselor's comments: none.)

Twenty-two percent of the referrals were for time-out from the classroom situation. The teachers' comments indicated in all of the cases that were studied the time-out occurred following the occurrance of negative (undesirable) behavior. These behaviors had either been occurring for a while and the teacher was becoming "fed-up" with the student's actions, or occurring immediately after a severely disruptive incident. Some examples of this type of referral are given below.

> Very "antsy"--can't stay still and follow instructions with student teacher. Wants to come to counseling center. Constant "playing" with objects in his desk. (Counselor's comments: I talked with the student and he seems ready to listen. I will contact home as soon as team consultation form is received.)
>
> Defiant, hitting other children, carelessly running at the teacher fist first. (Counselor's comment: Kept in office all day. Principal called the mother to discuss incident.)

Nearly eight percent of the referrals to the counseling center were for problem-solving, usually to help the student understand the consequences of a specific behavioral incident. Some examples of this type of referral are presented below.

> Hit 2 boys with jump rope. (Counselor's comments: It sounded like an accident and student said he will apologize to the other boys. Talked to him about the problem of safety.)
>
> Poked another student in the eye before school. (Counselor's comments: Student told me that he did not take his medication this morning. I called the mother. Student said that this morning was an accident.)

Other types of assistance that were requested for reward and recognition (1.8 percent), and from group counseling (0.5 percent). Examples of reward and recognition and group counseling are given below in respective order.

> Student earned 10 minutes of computer time for all the happy faces he's earned (on behavioral contract). (Counselor's comments: Student worked on computer. He was cooperative and requested a certificate. We agreed that if he earns reward time on Thursday, I'd give him a certificate.)
>
> Trouble paying attention. (Counselor's comments: We are going to work on listening. If the student gets points for listening well on Friday, he can come to the CC for a certificate with a stamp.)

Six percent of the assistance given was categorized by the teachers as other. Some examples of this type were requests to contact the parents regarding need for their children to be taking prescribed medications, or to notify parents of their children's behavioral and/or learning difficulties. Other examples were a direct referral from the playground because of a behavioral incident. Many requests of this nature specifically asked the counseling center staff to help children organize themselves or learn other task-related behaviors.

The 152 project participants had 792 referrals to the counseling centers at the four project schools. Most of the referrals were for individual counseling primarily due to disruptive or aggressive behavior, for a task such as completing an assignment, or to discuss areas needing improvement. Time-out was frequently requested particularly following specific behavioral incidents usually aggressive in nature. It's not clear whether the counseling center served to provide time-out for the student or for the teacher. Although the counseling center staff provided intervention to find out the cause of the incident and develop an alternative course of action with the student. Interestingly, referrals were less likely to be made for problem-solving, recognition and reward, and group counseling. The focus of the intervention given by the counseling centers appeared to be oriented toward providing assistance for a specific behavioral incident on an individual basis with the student. Guidance Services staff monitoring the project need to ensure that careful and comprehensive recordkeeping takes place.

Case study profiles. Three children were identified by district counselors as representative of the project participants, and case studies were prepared to profile in-depth the children's academic and behavioral characteristics, cite interventions, and the status of each case at the end of the school year. These case studies are presented below.

Student A

Student A is a seven-year-old boy who was referred to the consultation team at one of the project elementary schools because of his uncontrollable behavior in the classroom. Since he also had extreme difficulty with staying on task, his academic work suffered both in quality and through non-completion. His parents related a history of uncontrollable behavior (extreme hyperactivity), negative interactions with peers and destructive behaviors (biting, pushing other children, abusing a dog, starting a fire in rug at home) which began in infancy. Four different preschools were attempted, but they apparently could not handle him. At one, according to the mother, he was nicknamed "Jaws II" because of he bit the other children. He attended kindergarten at another district elementary school, and, then, transferred to the project school in first grade because of its after-school child care program. He was discontinued in the child care program because his behavior could not be managed by the child care staff.

The parents sought help from a psychologist in private practice who attempted to work with the family to develop a behavioral management system. A private pediatrician also became involved and prescribed Ritalin to deal with the hyperactivity. Academic and intellectual assessment was done by the school psychologist and resource specialist at the school near the end of the first semester. It was determined that he did not qualify for special education as learning handicapped. His overall intelligence was above average, and his achievement scores were within the average instructional range in a one-to-one testing situation. His reading teacher noted that he had a severe deficit in his ability to attend to his work, remember directions presented orally, and follow-through with assignments. He reportedly required constant supervision by the teacher to complete his class work. The Comprehensive Tests of Basic Skills was administered in April 1987, and the student earned the following percentile ranks: total reading, 1st percentile; language expression, 16th percentile; and, total mathematics, 4th percentile. All of these percentiles are substantially below grade level and below a percentile which could be attained simply by "guessing."

During the second semester, Student A was often sent to the counseling center, or to the principal's office where he would sometimes stay the remainder of the day because he could not settle down in the classroom. Parents were not able to pick him up on these "difficult days" as they were working full-time. Behavior contracts were set up with the teacher which outlined specific behaviors (staying in seat, hands to self, etc.) for which he would receive stickers and reward time. This enabled the teacher to manage the behavior within a tolerable level for short time intervals, and the contract needed to be changed every couple of weeks. Over the school year, Student A had 51 referrals to the counseling center. In the spring he was referred to special education for a second time by the school's consultation team because of the severity of his emotional problems. The last week of school he was found eligible for placement in the severely emotionally disturbed program and will be placed in special education in the fall. The ways in which interventions and follow-up as part of the K-6 Early Intervention Project will be provided have not been determined.

Student B

Student B is a ten-year-old boy who was enrolled in third grade at one of the project elementary schools. He had attended that school since 1982 and was retained in kindergarten. Beginning in kindergarten, he received special education assistance in speech therapy and adaptive physical education. The adaptive physical education assistance was discontinued the following year. He was tested for placement in the special education program, but did not qualify as he was achieving at the level of his intellectual ability. Review of the school records indicated that the student had a history of a short attention span and distractable and disruptive behaviors, which seemed to increase this past year. He received 24 referrals to the counseling center during the past school year for disruptive behaviors in the classroom, such as throwing pencils, making noises "like a pig," refusing to do work, kicking tables, and hitting other students. Academically, his teacher reported that he was having difficulties in reading, mathematics, and written language and described him as having poor retention, difficulty staying on task, difficulty comprehending directions and subject matter, and getting easily frustrated. She reported that his rate of completing assigned tasks was very slow. On the CTBS, which was given in April 1987, the student earned the following percentile ranks: total reading, 39th percentile; spelling, 27th percentile; total language, 62nd percentile; and, total mathematics, 55th percentile.

The beginning of the year seemed to be a particularly difficult time for the student, with problems reported to be occurring at home. His mother began taking him to counseling at a neighborhood social service agency, and the district counselor began seeing him on a regular basis at school. She established a behavioral contract system with his teacher. He appeared to be responsive to the individual counseling sessions, but was still having difficulties in the classroom. Medication was prescribed by the family's physician for the hyperactive behaviors and, after some adjustment to the dosage, the student began experiencing some real successes in school. His impulse control was reported to be improving. By the end of the year, Student B was beginning to understand and use conflict resolution methods to solve problems that he was having with other children on the playground. Classroom behavior also improved, although he would sometimes get stubborn and angry if he felt criticized. Completion of classroom assignments will be a focus of the counseling center program for Student B next year.

Student C

Student C is a ten-year-old girl who attended one of the project schools as a fourth grader. Records indicate that she attended other district schools in first and second grades, and, for a short time during third grade, attended another school district. In the past, her teachers have reported that they were "...pleased to see her trying so hard, but she continues to have her ups and downs." She lives with her mother, a single parent, but has expressed to several staff members that she prefers to live with her father and stepmother. Several child abuse reports were filed after the student related incidents of physical abuse. Health records showed recurrent problems with ear infections, and she had many absences due to illnesses or personal reasons, and was frequently requesting to go to the nurses' office for somatic complaints (upset stomach, headache, etc.). A physical examination by the family physician conducted over the past year yielded no significant problems. Her performance on the CTBS earned her the following percentile ranks: total reading, 69th percentile; total language, 64th percentile; and, total mathematics, 52nd percentile. All of these percentiles are above grade level.

The student was referred to the school's consultation team in February because of behavior problems in the classroom, academic difficulties, and high rate of absenteeism. Her teacher reported that the student was extremely active and restless at times, had difficulty staying on task, and was easily discouraged. The student had received five behavioral referrals to the counseling center for "loud obnoxious noises," banging things, refusal to do work, and bothering others. She was also sent to the counseling center a number of times when she became upset for no apparent reason in the classroom. The district counselor began seeing Student C on a regular basis, using a behavioral contract system, and allowing for some "talk time" through problem-solving sessions. The student's visits to the nurse decreased and classroom behavior seemed to improve during this time. She seemed eager to please and responded well to the positive reinforcement available through the individual counseling sessions. In the spring, Student C was absent for several weeks when she ran away with some older boys. Shortly after her return, she was injured while riding her bike and was briefly hospitalized with bruises and a neck injury. Toward the end of school,

the student began telling classmates that her life was being threatened by a man who was phoning her house. Through this traumatic spring, the student continued to be seen for individual counseling sessions at least one time weekly and the district counselor remained in contact with the mother. The student is on the waiting list to attend a magnet school in the district for next year.

These case studies show both the similarity and diversity among the project participants in terms of the types of problems that the students were having at school. All three students were reported to have experienced behavioral problems in the classroom such as difficulty staying on task and completing assignments; making disruptive noises, and difficulty getting along with peers. All three students were processed through the site's consultation team. Each student had a number of behavioral referrals to the counseling center for individual counseling or time-out sessions. Medication was prescribed by the family physicians for both Student A and Student B and served as a pharmacological intervention. Student A had the most severe problems and was placed into special education. The psychiatrist consulting with the project described Student A as showing very extreme symptoms of attention disorder deficit with hyperactivity. Student B had previously received special education services. Academically, two of the three students were achieving close to grade level, and all three were generally considered to have intellectual abilities in the average to above average range. Two of the three students (Student A and C) were likely to attend another school next year. The ways in which follow-up will be provided to these project participants has not been determined at this time.

V
SUMMARY AND CONCLUSIONS

Key findings of the evaluation study are presented below in summary form.

1. A five-step screening procedure consisting of parent and teacher referrals, health and developmental history, questionnaires, and assistance through the consultation team process and the counseling center program was developed and implemented by the Guidance Services Department to identify children in four elementary schools who might benefit by inclusion in the K-6 Early Intervention Project.

2. One hundred and fifty-two children, or 5.8 percent of the combined student enrollment of the four project schools were included as project participants. Follow-up interviews with the consultation teams at the four schools were conducted during spring 1987 identified 20 more children who were not currently included in the project but might benefit from the early intervention. Many of these children had not been originally referred because the parents or teachers did not perceive the children to be in need of the intervention services, or the children were receiving other interventions.

3. All or nearly all of the teachers had referred students to the K-6 Early Intervention Project at two of the project schools (Alcott and McKinley). At two of the schools (Hickman and Logan), slightly over half of the teachers referred students for intervention services.

4. Eighty percent of the project participants were boys, and 20 percent were girls. Fifty project participants (32.9 percent) were identified as Hispanic; 66 participants (43.4 percent) as White; 31 participants (20.8 percent) as Black; three participants (2.0 percent) as Filipino; and two participants (1.3 percent combined) as American Indian and Pacific Islander. Black students were overrepresented more than ten percent among project participants at two of the project schools. They were underrepresented at the other two project schools

5. The performance of the project participants on the Comprehensive Tests of Basic Skills indicated a wide variability in their levels of academic achievement which ranged from zero to the 99th percentile. Many project participants earned percentile ranks at or above the publishers' test norm of the 50th percentile for grade-level performance (40.5 percent of the participants in reading; 27.4 percent in language; and 37.6 percent in mathematics). However, the percentile ranks for the total group were skewed toward the lower end of the distribution.

6. Ninety percent of the project participants displayed extremely active or restless behavior. Seventy percent had trouble staying on task, and approximately 50 percent had poor peer relations or difficulties with self-control. These characteristics correspond to the symptoms of the children to be targeted as recipients of the early intervention by A.B. 1535.

7. As indicated by their IOWA Conners pretest and posttest rankings of project participants, the teachers perceived their students' behavioral problems to be more severe in February (pretest) then they did in June. The teachers ranked their students as displaying more serious problems than the parents' ratings. However, the teachers' posttest rankings more closely corresponded to the parents rankings than did their pretests rankings.

8. Item-by-item analysis of the teachers' rankings and the parents' rankings on the IOWA Conners indicated that the teachers tended to view inattention and over-active behaviors as more of a problem, and the parents viewed aggressive behaviors as greater problems for the same children. This finding suggests that the intervention services to teachers need a different focus from those made available to parents.

9. Twenty-eight percent of the referrals made to the counseling centers at the four project schools were for individual counseling interventions; 22 percent were for time-out; and, eight percent were for problem-solving. Other types of counseling interventions were for reward and recognition and group counseling. The referrals came about primarily for specific behavioral incidents that caused disruptions in the classroom and counseling assistance was provided on an individual basis with the student.

10. In-depth case study profiles of three project participants showed that each of the students had difficulty staying on task, made disruptive noises, and had poor peer relations. Academically, two of the three students were achieving close to the publisher's norms for grade-level performance on the CTBS, and all three were considered by school staff to have at least average abilities. Two of the three students were likely to attend another school in the fall. The ways in which follow-up will be provided to these students were not clearly specified at the end of the school year.

Conclusions. The K-6 Early Intervention Project was implemented in San Diego Unified School District, and the guidelines contained in A.B. 1535, Pilot Project on Hyperactivity were followed. The five-step screening process was in operation during the first year of the project's implementation. The guidelines for including or excluding children, particularly, those who are receiving other interventions for follow-up to project participants who attend another school or are promoted into seventh grade, are not currently in place and need to be developed particularly in light of the record-keeping to be required over time as specified in the legislation.

The high numbers of Black students among the project participants relative to their representative numbers at the project schools is of particular interest. Black students (particularly males) tend to be overrepresented in the district's high risk populations (see Special Education Annual Program Evaluation, Evaluation Department Report No. 473, October 6, 1987; Promotion and Retention Policy Implementation Study, Evaluation Department Report No. 463, June 30, 1987). Classroom teachers' expectations and their perceptions of the severity of students' academic, social, health, and speech/language problems served to initiate the process. It is interesting to note that project participants, on the average, were rated by the teachers as having less severe problems in June than when rated earlier in the year. Possibly as the teachers interacted with the counseling and resource staff through the consultation team process and school-site counseling center, they became better able to handle the students and changed their perceptions about the severity of students' problems. However, the reasons why a disproportionate number of Black students were rated by teachers to have severe problems and referred in the first place needs to be examined. As part of the K-6 Early Intervention Project, it is recommended that the specific reasons why teachers are referring Black students be studied, comprehensive data on the intervention attempted with the students be collected, and the efficacy of the interventions as a result of the three-year project be examined.

The interventions that were provided to the project participants were primarily individual counseling or time-out for specific behavioral incidents. The project participants were displaying disruptive behaviors in the classroom and having problems settling down to do class assignments. Teachers tended to rank inattentive and overactive behaviors as severe problems, and parents ranked aggressive behaviors as greater problems for the same children. This suggests the assistance given to teachers may need to focus on managing inattentive, overactive behaviors which may be disruptive to the classroom and interfere with optimal learning. Assistance given to parents may need to focus on management of their children's aggression. Many of the project participants were performing at least at grade-level. In general, it appears that the K-6 Early Intervention Project is providing intervention services to elementary school children who are not likely to be picked up by other district programs. The specific interventions attempted with the project participants need to be examined more closely over time to determine their actual effectiveness relative to reducing childhood antisocial behavior, enhanced academic performance, and improved social adjustment. The project should be evaluated in the third year to determine if the goals drawn up by the Joint Task Force on Hyperactivity of the California State Department of Justice and the Department of Education were met by the district's K-6 Early Intervention Project.

VI
RECOMMENDATIONS

The following recommendations are based on the conclusions stated in the preceding section.

1. It is recommended that guidelines be developed to determine whether children who are receiving pharmaceutical or special educational interventions should be included as participants in the K-6 Early Intervention Project. Clear guidelines also should be developed to establish the type of follow-up which will be provided for project participants for the duration of the three-year project.

2. It is recommended that the Guidance Services Department establish a database on microcomputers to maintain records of the assistance provided to the project participants, nature of any serious disciplinary offenses, and the success or failure of the child in completing the school program to conform with A.B. 1535 guidelines.

3. It is recommended that the Guidance Services Department study reasons why teachers referred a disproportionate number of Black students to the project, collect comprehensive information on the interventions attempted, and evaluate the efficacy of the interventions over the three-year duration of the project.

4. It is recommended that the K-6 Early Intervention Program be evaluated during the final year of implementation to determine the extent to which the project goals on staff participation, parent participation, and community involvement are met through inservice to teachers and parents, coordination of community resources, and counseling interventions for parents and students.

VII
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APPENDIX A
CONSULTATION TEAM PROCESS:
TEACHER RATING SCALE

CONSULTATION TEAM PROCESS

SAMPLE MEMO: TEACHER RATING SYSTEM

Date:

Memo to: Classroom Teacher

_____ Elementary School

From: District Counselor

I am implementing a Teacher Rating System for early identification of students with varied and unique needs. This procedure should also enable support staff to plan with you appropriate assistance for priority needs.

Giving consideration to student's priority needs in these areas: 1) academic, 2) personal/social, 3) health and 4) speech/language, please rate <u>each</u> student in your class list as follows:

- # 1 - Students that you feel <u>do not</u> appear to have any problems in any of the above areas.
- # 2 - Students that you feel appear to have <u>some</u> problems in <u>any or all</u> of the above areas.
- # 3 - Students that you feel appear to have <u>severe</u> problems in <u>any or all</u> of the above areas.

If at some point in the future you feel the student's needs have changed, i.e., from a #1 to a #2 to a #3, please notify me of that change.

Please return the list to my box by _____.

Thank you for your assistance.

APPENDIX B
CONSULTATION TEAM - REQUEST FOR SUPPORT SERVICES

CONSULTATION TEAM - Request for Support Services* Page 1

STUDENT _____ DOB _____ ETHNIC CODE _____
ADDRESS _____ HOME PHONE _____
SCHOOL OF RESIDENCE _____
SCHOOL OF ATTENDANCE _____ TEACHER _____ GRADE ____ ROOM ____
PARENTS or _____ WORK PHONE _____
GUARDIAN _____ WORK PHONE _____
LICENSED HOME _____
PRIMARY LANGUAGE OF HOME _____ STUDENT _____ LAU CODE ____
SIBLINGS/AGES _____
REFERRED BY _____ ADMINISTRATOR'S APPROVAL _____
DISTRICT COUNSELOR _____ DATE _____

SCHOOL HISTORY: ATTENDANCE PROBLEMS ____ EXEMPTIONS ____ SUSPENSIONS ____ SIP'S ____
(Circle Holdovers)

DATE	GRADE	SCHOOL	DATE	GRADE	SCHOOL	DATE	GRADE	SCHOOL

TEACHER INFORMATION: (Please check those items which describe the student)

HEALTH/PHYSICAL FACTORS
__1.Health problems__frequent health complaints
__2.Frequent absences, truancy
__3.Appears pale, listless, apathetic
__4.Extremely active and restless__fidgets
__5.Possible deficit: vision_hearing_
__6.Poor motor coordination: fine_ gross_
__7.Growth or development lag
__8.Physical injuries (not from abuse)

EDUCATION FACTORS
__1.Academic difficulties:Reading_Math_Written _
__2.Poor retention of subject matter
__3.Poor handwriting or reversals__messy work
__4.Difficulty staying on task__inattentive_distracted
__5.Difficulty comprehending directions & subject matt
__6.Difficulty changing activities
__7.Easily discouraged, frustrated
__8.Rate of work completion:Rushed__Slow__Fails to finish__

SPEECH/LANGUAGE FACTORS
__1.Difficulty understanding spoken language
__2.Difficulty relating ideas, limited vocabulary
__3.Articulation problem
__4.Incomplete sentences, poor grammar
__5.Needs directions repeatedly
__6.Responds inappropriately
__7.Voice quality
__8.Unusual rhythm/fluency__talks excessively

PERSONAL/SOCIAL FACTORS
__1.Generally withdrawn, timid, fearful inappropriate
__2.Poor self-control:temper outbursts__language
__3.Poor peer relations:fights_disturbs others_
__4.Seems unhappy__moody__cries easily__
__5.Feelings of inadequacy, low self-concept
__6.Fantasizes, exaggerates__, lies__
__7.Challenges authority, defiant__,impulsive__
__8.Shows little empath/concern for others

Student's Strengths: _____

___1. Creativity
___2. Sense of humor
___3. Physical strength & coordination
___4. Cooperative
___5. Enthusiastic
___6. Good motivation
___7. Highly verbal
___8. Confident: socially/academically
___9. Compassionate

PRESENT CLASSROOM FUNCTIONING: (grade levels): Reading ____ Math ____ Language ____
TEACHER CONSULTATION: DC ___ RSP ___ Nurse ___ LSH ___ Other _____

PARENT CONTACTS: (Significant contacts made by any staff member)
Date By Whom Purpose/Outcome

Have Parents Initated Contacts? Yes___ No ___

CONSULTATION TEAM - Planning Sheet*

STUDENT _____ DOB _____ SCHOOL _____ GRADE ____ ROOM ____

TEAM CONSULTATION MEETING: REQUESTED BY _____ DATE HELD _____

TEAM MEMBERS PRESENT _____

SIGNIFICANT TEST DATA: Regular Education
(Percentiles or Standard Scores)

Date _____ Test & Form _____ Scores
Date _____ Test & Form _____ Scores
Date _____ Test & Form _____ Scores
Date _____ Other Test Data _____

READING			LANGUAGE				MATH		
V:	C:	T:	SP:	M:	X:	T:	CP:	C/A:	T:

Special Education Assessment: No ___ Yes ___ Certified: No ___ Yes ___ Current? ___

SUPPORT STAFF COMMENTS: (summary of significant observations, services and referrals)

STAFF ACTION PLAN: (To be completed during the Consultation Team Meeting)

PRIOR (dates)	SERVICES	PROJECTED (check)	ACTION PLAN TO BE INITIATED	PERSON(S) RESPONSIBLE	COMPLETION DATE
	SITE CHANGES				
_____	Classroom Changes	___			
_____	Tutorial	___			
_____	Basic Skills	___			
_____	Reading Lab	___			
_____	Miller-Unruh	___			
_____	Math Lab	___			
_____	LEP/NEP	___			
_____	Other	___			
	SUPPORT SERVICES				
_____	DC/C Center	___			
_____	LSH	___			
_____	APE	___			
_____	Community Services	___			
_____	Nurse	___			
	SPECIAL ED. PROGRAMS				
	CH				
_____	LH	___			
_____	PH	___			
_____	SH	___			
_____	OTHER _____				

FOLLOW-UP MEETING PROJECTED: YES ___ NO ___ DATE _____ CASE MANAGER _____

Distribution: Original - Cumulative School Record Copy - District Counselor
*Documentation of modifications and/or alternatives as stated in the Education Code Section 5603.

APPENDIX C
K-6 EARLY INTERVENTION PROJECT
PARENTAL PERMISSION FORM

SAN DIEGO CITY SCHOOLS
Guidance Services Department
K-6 Early Intervention Project

Parental Permission Form

Student_____Birthdate_____Age____Sex____

School_____Teacher_____Grade____Room_____

Parent/Guardian(s)_____

Work Phone: Father_____Mother_____Home Phone:_____

Address:_____
Street City Zip Code

Your child has been referred to the K-6 Early Intervention Project. Project staff may obtain information about your child through behavioral inventories, health history, and working with your child on an individual basis. All information will be kept confidential.

I agree to allow my child to participate in the K-6 Early Intervention Project.

_____
Parent/Guardian(s) Signature Date

_____
Counselor's Signature Date

APPENDIX D
HEALTH SERVICES DEVELOPMENTAL HISTORY

San Diego City Schools
Health Services Department

CONFIDENTIAL

HEALTH SERVICES DEVELOPMENTAL HISTORY

Date: _____
School: _____
Nurse: _____
ID #: _____

Student's Name _____
Informant _____ Relation to Child _____ Birthdate/Age

SCHOOL HISTORY

1. Did your child attend preschool? Yes _____ No _____ Where? _____
2. Does he/she like school? Yes _____ No _____
3. What is your child's best school subject? _____
4. What is your child's weakest school subject? _____
5. Has your child missed a lot of school? _____ Reason _____
6. What kinds of things does he/she like to do best of all? _____

_____

7. Is your child right-handed, _____ left-handed _____ both _____
8. Did your child repeat a grade? Yes _____ No _____ If so, what grade _____
9. What special educational help has your child received? _____

_____

PAST MEDICAL HISTORY

1. Has your child had to stay in the hospital overnight? Yes _____ No _____
2. Check ( ) which of the following illnesses your child has had:

_____ measles
_____ mumps
_____ chicken pox
_____ strep throat
_____ dehydration
_____ bladder/kidney problems
_____ ear infection
_____ convulsion
_____ other (explain) _____

_____ asthma
_____ frequent/constant colds
_____ pneumonia
_____ bronchitis
_____ meningitis/encephalitis
_____ epilepsy
_____ tonsillitis
_____ sustained high fever
_____ allergic reaction

_____

_____

Known to any community agencies: No ____ Yes ____ Name: _____

HE 518
Rev. 12/80

PAST MEDICAL HISTORY (cont'd)

3. Check ( ) if your child has had any of the following:

_____serious burn
_____poisoning
_____broken bones
_____cuts needing doctor's care
_____other (explain)_____

_____near drowning
_____bee sting
_____auto accident
_____surgery (explain)
_____

_____

PRESENT MEDICAL HISTORY

1. Current medical conditions _____

2. Is your child experiencing eating problems? Yes _____ No _____
sleeping problems? Yes _____ No _____
vision problems? Yes _____ No _____
hearing problems? Yes _____ No _____
activity limitations? Yes _____ No _____

3. Is your child on any medication at the present time? Yes ___ No_____ Explain_____
Previous medications:_____ _____.

4. Who is your child's current physician(s) ?_____
Date of Last Physical _____

FAMILY HISTORY

1. With whom does the child live? Please circle answer.

a. Mother: natural mother, adoptive mother, foster mother, stepmother, other_____

Age:_____

b. Father: natural father, adoptive father, foster father, stepfather, other_____ Age_____

2. Others in Family:
Ages of brothers:
Ages of sisters:
Others: Relationship:

How many people live in your home? Children _____ Adults _____

3. What languages are spoken in the home: _____

4. Are there any members of your child's immediate family (brothers, sisters, parents, grandparents, aunts, uncles) with a serious learning or health problem (mental or physical)? List each problem and who has it.

_____
_____
_____

FAMILY HISTORY (continued)

5 Does anyone help you take care of your child on a regular basis? Yes ____ No _____

6 Has the child lived with you continuously since birth? Yes _____ No _____
If not, with whom did child live?_____

PREGNANCY (this relates to the child's natural mother)

1. Did you have any serious health problems (mental or physical) before this pregnancy? Yes _____ No _____
If so, what?_____

2. How many time have you been pregnant?_____

3. How many miscarriages have you had?_____

4. When did you begin receiving medical care during your pregnancy with this child?
_____

5. Number of pounds gained during pregnancy_____
Drugs taken during pregnancy_____
Did you regularly use cigarrettes and alcohol during pregnancy?_____

6. Did you have any infections, illnesses, accidents or injuries during your pregnancy? If so, what?_____

7. Did you have any severe emotional stress during this pregnancy? Yes_____ No _____

8. Was your baby born early, on time, or late?_____

9. Frequent minor illnesses (Colds, rashes, etc.)?_____

BIRTH

1. How long was your labor?_____

2. Describe any complications during labor?_____

3. Type of delivery: Vaginal_____ Breech_____ Forceps_____
Cesarean Section_____

4. Did you receive medication during labor? Yes _____ No _____

5. Did you receive medication during delivery? Yes _____ No _____

NEWBORN

1. Did your baby have any trouble starting to breath?_____

2. How much did he/she weigh at birth?_____

3. Did your baby have any obvious birth defects? Yes _____ No _____

NEWBORN (continued)

4. Did your baby have any trouble in the hospital? Yes _____ No _____

5. How long did he/she stay in the hospital?

6. Did your baby have severe colic or any unusual feeding problems? Yes _____ No_____

7. Was your child's weight gain normal during the first three months? Yes____ No_____

8. Did your child have any illness during this period ? Yes _____ No _____
   If yes, explain_____
   _____

9. Indicate your baby's activity level:
   quiet____, usual activity____, exeessive activity____.

DEVELOPMENT (list age if known)

	Slow	Average	Fast
Show response to mother (birth - 1 month)			
Roll over (2 - 5 months)			
Sit alone (6 - 11 months)			
Crawl (8 months)			
Walk alone (11 - 15 months)			
Babble (5 - 10 months)			
Speak first word (9 - 13 months)			
Put several words together (15 - 28 months)			
Dresses self (2 ½ - 4 3/4 yrs)			
Toilet trained (18 - 30 months)			
Stay dry at night (1 ½ - 5 yrs)			
Feed self (10 - 24 months)			
Ride tricycle (3 yrs)			

LANGUAGE - Check ( ) those that apply to your child.

_____speech easy to understand
_____unclear or immature speech
_____difficulty relating ideas
_____answers don't make sense
_____limited vocabulary
_____responds slowly
_____short attention
_____short attention span
_____needs directions repeated

If child has trouble speaking, what is his way of communicating?_____
_____

EMOTIONAL ADJUSTMENT, BEHAVIOR, DISCIPLINE

1. Check ( ) the following behaviors which describe your child:

_____tires easily
_____withdrawn
_____very shy
_____will not mind
_____jealous
_____shares
_____talkative
_____tantrums
_____nightmares
_____falls alot
_____difficulty sleeping
_____gets along with others
_____doesn't like to be touched
_____behavior consistent
_____easily managed
_____concern when separated from parents
_____rocks in crib
_____stares at lights; people, objects

EMOTIONAL ADJUSTMENT, BEHAVIOR, DISCIPLINE (continued)

1.

_____hyperactive
_____quiet
_____generally happy
_____bangs head
_____aggressive
_____

_____slow to learn
_____thumb sucking
_____breath holding
_____gives up easily
_____destructive
_____stubborn

Indicate which of the above listed behaviors concern you most by circling the ( )

2. Is there any other behavior not listed that concerns you? Yes_____ No_____
If so, what is it:_____

3. Self-Help Skills (check ( ) if does activities regularly)

_____feeds self
_____dresses self
_____makes bed
_____helps with household chores
_____runs errands (outside home)

_____knows money concepts
_____has a part-time job
_____uses a public transportation
_____babysits
_____personal hygiene

4. How does your child get along in family?_____ _____
_____

5. What have you found to be the most effective way of disciplining your child?

_____send to room
_____spank
_____ignore
_____other:_____

_____reward
_____reason
_____take privileges away

6. Describe your child's best qualities._____
_____

7. How does your child feel about his/her school performance?_____
How do you feel about his/her school performance?_____

8. Please add anything else you want us to know about your child._____
_____
_____

IMPRESSIONS OF CHILD'S PRESENT STATUS

San Diego City Schools
Educational Services Division
Guidance Services Department

K-6 Early Intervention Project
Addendum to Health Services Development History:

1. Does your child habitually eat breakfast? Yes___ No_____

2. Does your child crave or eat unnatural substances such as chalk, ashes, or dirt? Yes_____ No_____
If yes, what substance?_____

3. Has your child been diagnosed as having lead poisoning? Yes_____ No_____

4. Has your child been exposed to lead: from a parent's occupational source?_____from treatment with home remedies containing lead?_____from regularly eating food prepared or stored in lead-containing pots? Yes_ No_____

5. Is there a family history of hyperactivity? Yes_____ No_____If yes, describe:_____

This medical history should be taken by the nurse according to the usual district protocol. Please be certain that the sections of the Health Services Developmental History on Emotional Adjustment, Behavior and Discipline (page 4) are complete.

BEST COPY AVAILABLE

APPENDIX E
IOWA CONNERS PARENT-TEACHER QUESTIONNAIRE

SAN DIEGO CITY SCHOOLS
Educational Services Division
Guidance Services Department

IOWA CONNERS PARENT-TEACHER QUESTIONNAIRE

Name_____ Birth Date/ I.D. No._____ Grade___ Sex: __M __F

School_____ Teacher's Name_____

Completed by: Mother___Father___Teacher___Other_____ Date Completed_____

Instructions: Check each of the behaviors listed below according to how well it describes the student at this time.

Observation	Not at All	Just a Little	Pretty Much	Very Much
1. Fidgeting				
2. Hums and makes other odd noises				
3. Excitable, impulsive				
4. Inattentive, easily distracted				
5. Fails to finish things he or she starts - short attention span				
6. Quarrelsome				
7. Acts "smart"				
8. Temper outbursts, explosive and unpredictable behavior				
9. Defiant				
10. Uncooperative				

	None	Minor	Moderate	Severe
11. How serious a problem do you think this child has at this time?				

Comments: _____

CP:1b
Rev. 2/9/87

APPENDIX F
STUDENT ASSISTANCE REFERRAL PASS

SAN DIEGO CITY SCHOOLS

STUDENT ASSISTANCE REFERRAL PASS

SCHOOL

NAME(S)		SEX	ETHNIC CODE	REFERRED BY	TO
TEACHER	PERIOD	ROOM	GRADE	DATE	TIME IN

PURPOSE (CHECK)

INDIVIDUAL COUNSELING*	
PROBLEM SOLVING*	
TIME-OUT*	
REWARD/RECOGNITION	
GROUP COUNSELING	
GUIDANCE GROUPS	
OTHER	

PRIOR EFFORTS TO ASSIST STUDENT* (CHECK)

___ COUNSELED STUDENT ___ PARENT CONTACTED

___ ROOM CHANGES ___ ADMIN. CONTACTED

___ OTHER _____

REFERRAL RELATED TO* (CHECK)

___ ACADEMIC PROGRESS ___ SOCIAL ADJUST.

___ HEALTH/PHYSICAL ___ PERSONAL ADJUST.

___ ATTENDANCE ___ OTHER_____

COMMENTS*

* COUNSELING DATA AND TEACHER COMMENTS REQUESTED

RETURN PASS

RETURN TIME

COMMENTS

___ STUDENT IS READY TO RETURN TO CLASS ___ RETURN STUDENT TO COUNSELOR

___ PLEASE SEE ME AT YOUR CONVENIENCE ON _____

___ PARENT CONTACTED ___ RECOMMEND CONFERENCE WITH

_____

Signed_____

Copies: Counselor (original), Teacher, Administrator, Other

22-S-1205

PRINTING SERVICES

APPENDIX G
K-6 EARLY IDENTIFICATION-INTERVENTION PROJECT
INTERVIEW FORM

SAN DIEGO CITY SCHOOLS
Educational Services Division
Guidance Services Department

K-6 EARLY IDENTIFICATION-INTERVENTION PROJECT

(Interview conducted with the Consultation Team including school principal, district counselor, resource specialist, school nurses, psychologist, and other site staff, as appropriate.)

As you know, the district has established a pilot K-6 Early Identification-Intervention Project at four schools to encourage the efficient utilization of available resources to try to meet the needs of "hyperactive" students. Research indicates that 5-10% of students will initially be identified as "hyperactive."

Let's quickly review steps that have been used at your school to identify the project participants. (See attached chart.)

This is the list of students identified as project participants at this school. (Show instruments and specific items.)

a. Can you think of additional students who haven't been included as project participants at this school and should be?

b. What are their names? Rooms? Grades?

c. Why do you think that these students were missed by the initial screening process?

d. Do you want them to go through the screening process now? (If no, why not?)

(Record names and information on page 2.)